Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2827	A. BUILDING _____ B. WING _____	10/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & L ADULT CARE HOME INC	1811 S 7TH STREET LAS VEGAS, NV 89104

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Y 000	Initial Comments This Statement of Deficiencies was generated as a result of the annual State Licensure survey conducted in your facility on 10/09/08. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The facility is licensed for 8 total beds. The facility was licensed as an 8 bed (3 Category 1 and 5 Category 2) Residential Facility for Groups which provides care to elderly or disabled persons and persons with mental illness. The census at the time of the survey was 7 residents. Seven (7) of 7 resident files were reviewed. Two (2) former resident files were reviewed. Four (4) of 4 employee files were reviewed. There were two (2) complaints investigated: Complaint # NV14476 was unsubstantiated Complaint # NV15233 was unsubstantiated The following regulatory deficiencies were identified:	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 051	Continued From page 1	Y 051		
Y 051 SS=C	449.194(2) Administrator's Responsibilities-Designation NAC 449.194 The administrator of a residential facility shall: 2. Designate one or more employees to be in charge of the facility during those times when the administrator is absent. Except as otherwise provided in this subsection, employees designated to be in charge of the facility when the administrator is absent must have access to all areas of and records kept at the facility. Confidential information may be removed from the files to which the employees in charge of the facility have access if the confidential information is maintained by the administrator. The administrator or an employee who is designated to be in charge of the facility pursuant to this subsection shall be present at the facility at all times. The name of the employee in charge of the facility pursuant to this subsection must be posted in a public place within the facility during all times that the employee is in charge. This Regulation is not met as evidenced by: Based on observation and record review on 10/09/08, the administrator failed to designate one or more employees to be in charge of the facility during those times when the administrator was absent. Findings include: Observation: The name of the employee in charge was not posted at the facility.	Y 051		

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Y 051	Continued From page 2 Document Review: The facility failed to provide a document designating the employee in charge during the absence of the administrator. A document designating an employee in charge during the absence of the administrator was available in Employee #1's personnel file. However, the name of the employee in charge during the absence of the administrator and the administrator's signature block was blank on this document. Severity: 1 Scope: 3	Y 051		
Y 085 SS=I	449.199(1) Staffing-CG on duty all times NAC 449.199 1. The administrator of a residential facility shall ensure that a sufficient number of caregivers are present at the facility to conduct activities and provide care and protective supervision for the residents. There must be at least one caregiver on the premises of the facility if one or more residents are present at the facility. This Regulation is not met as evidenced by: Based on observation and interview on 10/09/08 the administrator failed to ensure there was at least one (1) caregiver on the premises if one or more residents are present at the facility. Findings include: Observation:	Y 085		

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Y 085	Continued From page 3 On 10/09/08 at approximately 1:40 PM while attempting to conduct an annual survey of the facility, a person answered the door of the facility and identified herself as a cousin of Employee #2, a caregiver. The cousin said she just helped out and was not an employee of the facility. The cousin said Employee #2 had to take a resident to a dental appointment. The cousin informed the surveyors there were seven (7) residents at the facility, with six (6) currently on the premises. Interview: At approximately 2:10 PM Employee #1 who introduced himself as the Administrator, arrived at the facility. At approximately 2:20 PM Employee #2, and Employee #3 also arrived at the facility. Employee #2 stated "she did not wait for the bus and came straight to the facility from the dental office". Employee #2 added "Employee # 1 had just gone to a take a lunch break" Severity: 3 Scope: 3	Y 085		
Y 103 SS=D	449.200(1)(d) Personnel File - NAC 441A NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee.	Y 103		

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Y 103	Continued From page 4 This Regulation is not met as evidenced by: Based on record review on 10/9/08, the facility failed to ensure that one (1) of four (4) employees had the required tuberculosis (TB) screening documentation. Findings include: Employee #1's (date of hire 1/15/99) file contained proof the employee tested positive for TB. Employee #1 had a negative chest x-ray report dated 05/2006. The file did not contain a TB symptom surveillance form or a copy of a negative chest x-ray report required for those who test positive for TB in 2008. Severity: 2 Scope: 1	Y 103		
Y 273 SS=D	449.2175(4) Service of Food - Special Diets NAC 449.2175 4. A resident who has been placed on a special diet by a physician or dietitian must be provided a meal that complies with the diet. The administrator of the facility shall ensure that records of any modification to the menu to accommodate for special diets prescribed by a physician or dietitian are kept on file for at least 90 days. This Regulation is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure a special diet be provided for a resident as prescribed by a physician for 1 of 7 residents (Resident #1).	Y 273		

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Y 273	Continued From page 5 Findings include: Interview: Employee #2 confirmed that Resident #1 was not being served a diet as ordered by his physician. Document Review: The file for Resident #1 had a physician's order in it for an 1800 calorie ADA diet. Severity: 2 Scope: 1	Y 273		
Y 274 SS=C	449.2175(5) Service of Food - Substitutions NAC 449.2175 5. Any substitution for an item on the menu must be documented and kept on file with the menu for at least 90 days after the substitution occurs. A substitution must be posted in a conspicuous place during the service of the meal. This Regulation is not met as evidenced by: Based on observation and interview the facility failed to document and post in a conspicuous place substitutions in the menu. Findings include: Observation: The menu showed that turkey/ham sandwiches; potato salad and peaches would be served for the dinner meal on 10/09/08.	Y 274		

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Y 274	Continued From page 6 There was no available documentation for the meal plan substitution. Interview: Employee #2 stated that the residents were going to have frozen pot pies for the dinner meal on 10/09/08. Severity: 1 Scope: 3	Y 274		
Y 450 SS=F	449.231(1) First Aid and CPR NAC 449.231 1. Within 30 days after an administrator or caregiver of a residential facility is employed at the facility, the administrator or caregiver must be trained in first aid and cardiopulmonary resuscitation. The advanced certificate in first aid and adult cardiopulmonary resuscitation issued by the American Red Cross or an equivalent certification will be accepted as proof of that training. This Regulation is not met as evidenced by: Based on record review, the facility failed to ensure two (2) of four (4) employees had evidence of current training in first aid and cardiopulmonary resuscitation (CPR) (#1, & #4).	Y 450		

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Y 450	Continued From page 7 Findings include: Review of Employee #1's personnel file (date of hire 1/15/99) provided documentation of a First Aid and CPR card with an expiration date of 4/30/07. There was no further documentation regarding a current First Aid and CPR card. Review of Employee #4's file (date of hire 08/10/04) provided evidence of a First Aid and CPR card with an expiration date of 8/23/08. There was no further documentation regarding a current First Aid and CPR card. Severity: 2 Scope: 3	Y 450		
Y 876 SS=B	449.2742(4) NRS 449.037 NAC 449.2742 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.037 are met. This Regulation is not met as evidenced by: Based on record review, the facility failed to ensure that an agreement addressing possession and assistance in the administration of medications was signed for 3 of 7 residents. Findings include: The file for Resident #1, #2 and #4 failed to contain a signed agreement that authorized the	Y 876		

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Y 876	Continued From page 8 facility to administer medications to the resident. Severity: 1 Scope: 2	Y 876		
Y 921 SS=D	449.2748(2) Medication Storage NAC 449.2748 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. This Regulation is not met as evidenced by: Based on observation the facility failed to ensure that medication stored in the refrigerator was kept in a locked box. Findings include: Resident #3's cough medication was stored on a shelf of the refrigerator in the kitchen and was not in a locked box. Severity: 2 Scope: 1	Y 921		